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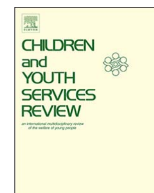

The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma☆

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A B S T R A C T

The current study examined the effectiveness of three trauma treatments in the context of a statewide, trauma-informed child welfare initiative to improve outcomes for children with complex trauma. Clinicians enrolled 842 children (birth-18 years) involved in the child welfare system within the past year and administered measures at up to three time points (baseline, 6 months, 12 months) to assess children's behavior problems, symptoms of posttraumatic stress disorder (PTSD), and strengths and needs using parent/caregiver, youth, and clinician report measures. The results of four-level regression models specified to account for non-independence of observations within children, and among clinicians and within agencies, indicated that trauma treatment was associated with significant improvements in child behavior problems, PTSD symptoms, strengths, and needs. However, results differed by treatment model, with optimal outcomes for children receiving Attachment, Self-Regulation and Competency (ARC) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Positive findings across multiple child outcomes suggest that trauma treatment is an effective means of improving the developmental trajectories of children with complex trauma, but that each model has specific strengths and weaknesses that should be taken into account when selecting a treatment model for this population.

1. Introduction

Child abuse and neglect is a widespread societal problem that often has devastating effects on children's development that persist into adulthood (Widom, Czaja, Bentley, & Johnson, 2012). In 2015, an estimated 4 million referrals for maltreatment were made to child protective services involving 7.2 million children (U.S. Department of Health & Human Services, n.d.). While individual child outcomes vary depending on the age of the child, the nature of the maltreatment, the relationship between the child and the perpetrator, and the balance of risk and protective factors in the child's life, research shows that the consequences of maltreatment can span multiple developmental domains and include negative alterations to brain structure and functioning, difficulties forming attachments, posttraumatic stress, internalizing and externalizing behaviors, and chronic health problems (Institute of Medicine & National Research Council, 2014; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013). While in the child welfare (CW) system, children may endure additional experiences of separation and loss in foster care. These chronic, interpersonal adversities that begin early in life are often referred to as complex trauma, and are associated with impairments in biology, attachment, affect regulation, behavioral control, cognition, and self-concept (Kisiel, Fehrenbach, Small, & Lyons, 2009; Spinazzola et al., 2013). Not surprisingly, children in the CW system are considerably more likely to require mental health (MH) services compared to non-maltreated children (Yanos, Czaja, & Widom, 2010).

Several therapeutic models have been developed to treat complex trauma and to promote positive developmental trajectories among maltreated children. Few have been rigorously evaluated, and they have shown varying levels of effectiveness (Leenarts et al., 2013).

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Moreover, little is known about how they compare to one another in producing their intended outcomes. To our knowledge, only one study has been conducted previously comparing outcomes of different trauma treatments for children involved in the child welfare system. Weiner, Schneider, & Lyons (2009) compared three treatment models (Child-Parent Psychotherapy [CPP], Trauma-Focused Cognitive Behavioral Therapy [TF-CBT], and Structured Psychotherapy for Adolescents Responding to Chronic Stress [SPARCS]), two of which are included in the current study (CPP and TF-CBT), and found they were equally effective in reducing symptoms and improving child functioning. However, this study was limited to children in out-of-home care, which represents less than one-quarter of children reported to child protective services (U.S. Department of Health & Human Services, n.d.). We examined the effects of three widely disseminated trauma treatments—Attachment, Self-Regulation, and Competency (ARC) (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005), Child-Parent Psychotherapy (Lieberman & Van Horn, 2004), and Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006)—on children's functioning (PTSD symptoms; behavior problems; needs and strengths). Treatment models were selected based on promising research of their effectiveness with complexly traumatized children, the projects' commitment to providing treatment to children from birth to age 18, and the availability of trainers to provide technical assistance and training in each model. Treatment was provided through a statewide trauma-informed care initiative implemented in CW, the Massachusetts Child Trauma Project (MCTP). See Bartlett et al. (2016) and Fraser et al. (2014) for additional information on implementation and first-year outcomes.

1.1. The Massachusetts Child Trauma Project

Multipronged, systemic efforts are essential to creating a trauma-informed CW system that effectively addresses complex trauma, yet there are few statewide initiatives such as MCTP. Central to the MCTP approach is trauma-informed care (TIC) infused throughout the service delivery system. MCTP's goals were to: (a) improve identification and assessment of children exposed to complex trauma; (b) build MH services to deliver trauma-specific, evidence-based treatments and practices in community agencies serving CW involved children; (c) increase referrals of children to trauma treatment; and (d) increase caregivers' awareness and knowledge of child trauma.

1.2. Current study

The current study examined the effectiveness of three community-based trauma treatments with CW involved children and youth. We assessed whether participation in treatment predicted positive child outcomes and compared outcomes by treatment model. We hypothesized that children and youth would exhibit more positive functioning, including reductions in PTSD symptoms, problem behaviors, and needs, and improvement in strengths following treatment. We also conducted an exploratory investigation of differential effects on child outcomes by treatment model.

2. Method

2.1. Sample and procedures

A total of 842 children in one of three trauma treatments participated in the evaluation. The study utilized a convenience sample. Clinicians ($n = 323$) were trained in one or more trauma treatment model and provided guidance on how to recruit eligible children: birth-18 years, English or Spanish speaking who had families involved in the CW system within a year of referral to MH agencies. MH agencies with clinicians that offered more than one treatment model were trained to pair children and youth with a treatment model based on their age and individual needs. Guidelines for treatment model selection were derived from the intended usage indications, empirical evidence-base, and history of successful implementation of each model with children and caregivers within and across three contextual parameters: developmental stage, caregiver involvement and primary clinical presentation (Fraser et al., 2014). Clinicians administered assessments at baseline (i.e., onset of treatment), 6, 12, and 18 months, or until treatment was complete or treatment was terminated. The protocol took approximately 1 hour to administer, although the length of time varied depending upon whether youth were old enough (≥ 8 years) to complete self-report measures and whether parents or other caregivers opted to complete some of the measures while waiting for the session to begin.

In the study sample, 44.89% ($n = 378$) children and youth received ARC, 35.99% ($n = 303$) received TF-CBT, and 18.76% ($n = 158$) received CPP. Children averaged 9.14 years at enrollment ($SD = 4.66$; *Range* = 0–18 years); ARC $M(SD) = 10.25$ (4.13), *Range* = 2–18 years; CPP $M(SD) = 3.38$ (1.53), *Range* = 0–7 years; and TF-CBT $M(SD) = 10.69$ (4.06), *Range* = 3–18. Over half of children (53.92%) were female. Approximately 4.35% were Hispanic, 70.31% were White, 18.65% were African-American, 1.7% were American Indian or Alaskan Native, 1.31% were Asian (others unknown); respondents were given the option to select as many categories and combinations of race/ethnicity as applied. Over one third (38.24%) were using psychotropic medication at baseline. Approximately 43.59% of children were in the legal guardianship of their parent and 38.12% were in state custody. Almost one quarter resided in foster homes (23.63%). The most common types of trauma they experienced were within the caregiving system (e.g., physical abuse, neglect, caregiver impairment; $M = 5.2$ out of 20 types) (http://www.nctsn.org/nctsn_assets/dcri/NCTSN_CCDS_Trauma_DetailVersion_4Final%20.pdf, n.d.).

2.2. Trauma treatment models

Three cohorts of clinicians, each in different regions of the state, were trained from 2012 to 2014 (one cohort per year) to provide one or more of the trauma treatment models through Learning Collaboratives, which included face-to-face learning sessions, monthly telephone coaching calls, supervisor coaching calls, and senior leader sustainability calls. Clinicians began to offer treatment to children and youth following the basic training for each model and continued to provide treatment throughout the four-year implementation period (2012–2016), as clinically indicated. Additional details on the implementation of each model are provided below.

2.3. Attachment, self-regulation, and competency (ARC)

ARC is a comprehensive, clinical objectives-driven intervention framework for children and youth who have experienced complex trauma. It is grounded in attachment theory, the effects of childhood traumatic stress on development, and resilience building. ARC is guided by three integrative strategies, eight primary clinical targets or building blocks, and one overarching goal of trauma experience integration (Blaustein & Kinniburgh, 2010; Kinniburgh et al., 2005). It was designed for children and youth age 2–21 years; in MCTP it was offered to children 3–18 years of age. Clinicians were trained through a 12-month Learning Collaborative (LC). A randomized controlled trial (RCT) of ARC is underway, and several observational studies derived from program evaluation have shown that it is a promising, evidence-informed clinical intervention (Achenbach & Rescorla, 2001; Arvidson et al., 2011; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998).

2.4. Child-Parent Psychotherapy (CPP)

CPP is a long-term dyadic attachment-based treatment model developed for children from birth to five years old that address trauma as

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